

FILED NOV 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36179

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 1297	
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph			
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2705 Patee				d. STREET ADDRESS (If rural, give location) 2705 Patee			
3. NAME OF DECEASED (Type or Print) a. (First) Mahilda		b. (Middle) Spurlock		c. (Last) Davis		4. DATE OF DEATH (Month) (Day) (Year) November 15, 1950	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Apr. 30, 1868	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Clarinda, Iowa		12. COUNTRY OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Perry Brown		13b. MOTHER'S MAIDEN NAME Eleanor Wells		14. NAME OF HUSBAND OR WIFE Charles Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. A. C. Holthaus Wichita, Kansas			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 mon.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Oct 11, 1950, to Nov 15, 1950, that I last saw the deceased alive on Nov 13, 1950, and that death occurred at 3:45 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Robert Conrad MD		23b. ADDRESS St. Joseph Mo		23c. DATE SIGNED Nov 15, 50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 17, 1950		24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
DATE REC'D BY LOCAL REG. Nov 18, 1950		REGISTRAR'S SIGNATURE Carl C. Casby		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS St. Joseph, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Robert W. Conrad

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*William Spalding*

Licensed Embalmer No. 4535

P. O. Address 319 S. 11<sup>th</sup> St. St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.